

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-013805

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

2841

STATE FILE NUMBER

VS-300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED MAR 20 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis, Mo.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bethesda.		d. STREET ADDRESS (If outside, give location) 3920a Giles Ave.	
3. NAME OF DECEASED (Type or print) First William, Middle J., Last Schroff.		4. DATE OF DEATH Month 3, Day 8, Year 63	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-14-88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired.		10b. KIND OF BUSINESS OR INDUSTRY National Lead.	
13a. FATHER'S NAME MATTHEW SCHROFF.		13b. MOTHER'S MAIDEN NAME Hedwig Streit.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Address Dorothy Schroff, 3920a Giles Ave.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding Esophageal Varices DUE TO (b) Cirrhosis of the Liver DUE TO (c) 581.0		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from Feb. 17, 1963 to March 8, 1963 and last saw him alive on March 8, 1963 Death occurred at 9:10 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22b. ADDRESS 16 Hampton Village Plaza St. Louis Mo.	
22a. SIGNATURE (Degree or title)		22c. DATE SIGNED 3-11-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial.	23b. DATE 3-12-63.	23c. NAME OF CEMETERY OR CREMATORY National.	23d. LOCATION (City, town, or county) St. Louis, County Mo.
24. FUNERAL DIRECTOR Southern Funeral Home. 6322 S. Grand Blvd.		25. DATE RECD. BY LOCAL REG. MAR 11 1963	26. REGISTRAR'S SIGNATURE Kearl Smith, M.D.

USE BLACK INK
OR
TYPEWRITER RIBBON

~~Dr. Ongjoho.~~

Dr. Ongjoho.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Harmer Dull

Licensed Embalmer No.

4347

P. O. Address

632 1/2 Grand Blvd.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.